

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04033

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04016

1. DECEASED NAME (Type or Print)	First	Middle	Lost	2a. DATE KNOWN OR ESTI- MATED	Month	Day	Year	2b. HOUR	
E112	DeMott	Bell		<input checked="" type="checkbox"/>	3/10	168	3 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS			2d. HOUR	
Female	white	10/13/1879	89 YRS	MONTHS	DAYS	HOURS	MIN.	4:15 P.M.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8.	MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
Ohio	U.S.A.						Dorchester		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
East New Market				None					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER					
Md.	Dor	East New Market	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	16. CO. LOST		
Clark	W.	DeMott		Melva		Cobb			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO	-	Mrs. M. H. M ^a Aiken	Eas ^t New Market				IMMED		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) CORONARY EMBOLUS									
DUE TO, OR AS A CONSEQUENCE OF									
4109									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause									
(b) ARTERIOSCLEROTIC HT. DISEASE UNDET									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
					<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
				19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Alfred R. Maryanov</u> M.D.									
EXAMINER'S NAME (Type) <u>ALFRED R. MARYANOV</u>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22b. DATE SIGNED <u>3/11/68</u>									
ADDRESS (Street, city, town, or county) <u>6107 31/5 Dorchester</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/13/68		23c. NAME OF CEMETERY OR CREMATORIAL East New Market			23d. LOCATION (City or Town) East New Market		
							(County) (State)		
24. FUNERAL DIRECTOR		ADDRESS Kathy S. Willoughby, East New Market, Md.		25a. RECD BY REGISTRAR MAK 12 1968			25b. REGISTRAR'S SIGNATURE James J. Jones		

#1005

66100

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04017

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

1. DECEASED-NAME (Type or print)	First ELLA	Middle GERTRUDE (McGrath)	Last Bowe	2a. DATE OF DEATH Month March	Day 13	Year 68	2b. HOUR 15 ¹⁶ p.m.
3. SEX F	4. RACE W	5. DATE OF BIRTH 08-31-85			6. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Dorchester			Md.
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eastern Shore State			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Md. W.F.			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Wicomico	13b. STATE Md.	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 7255, Division St			
14. FATHER'S NAME Cavett	First McGrath	Middle	Last	15. MOTHER'S MAIDEN NAME Elizabeth	First	Middle	Last WARRICK RITCHIE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT Mr. Harry L. Bowe (Son) Salisbury, MD Records - 855 H. Cambridge, Md			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 485 <input checked="" type="checkbox"/> Bouchopneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4918							
19a. DATE OF OPERATION 4/9/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 09-26, 1967, to 03-13, 1968, that (I) (we) last saw the deceased alive on 03-13 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. F. FERE		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 3/13/68		
22d. PHYSICIAN'S NAME (Type) L.F. FERE		22e. ADDRESS 855 H. Cambridge, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 15, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery		23d. LOCATION (City or Town) Salisbury, Wicomico, Maryland	(County)	(State)
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				ADDRESS	25a. REC'D BY REGISTRAR MAR 15 1968	25b. REGISTRAR'S SIGNATURE Charles J. George	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04018

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

11. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Year	2b. HOUR M					
Mary		Virginia	Carroll	3	1968						
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.		
Femal	white	Sept. 10, 1877		91		YRS.	MONTHS	DAYS	MIN.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	9. NEVER MARRIED DIVORCED	9. COUNTY OF DEATH		Dorchester					
MARYLAND	U.S.A.			Dorchester		Md.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Hurlock, Md.	Belle Haven Nursing			House wife							
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER							
MARYLAND	PRINCESS	SOMERSET	PRINCESS Anne	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>						
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last				
GEORGE W. KIRK				ANNIE, JR							
16a. WAS DECEASED EVER Yes, no, or unknown	IN U.S. ARMED FORCES? (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address							
NO		218.342954	KIRK CANNON, ROCKVILLE, MD								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Idiopathic Aplastic Anemia</u> 1 year											
284X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Senile cachexia</u> 4 years											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
2924		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION	Street or R.F.D. No.	City or Town	County	State			
22a. I certify that (I) (this hospital) attended the deceased from <u>March 11, 1968</u> to <u>March 11, 1968</u> , that (I) (we) last saw the deceased alive on <u>March 11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Carlos F. BARRERO		MD DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input type="checkbox"/>	22c. DATE SIGNED March 14, 1968		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 3 Main St Hurlock Dorchester Md									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/18/1968	23c. NAME OF CEMETERY OR CREMATORIAL SRING HILL		23d. LOCATION (City or Town) FASTON, MD		(County)		(State)		
24. FUNERAL DIRECTOR		ADDRESS VENNEMAN FUNERAL HOME, EASTON, MD		25a. REC'D BY REGISTRAR MAR 19 1968		25b. REGISTRAR'S SIGNATURE Charles J. Venneman					

3802

FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04036 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)	First Samuel	Middle Thomas	Last Cannon	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Mar 20 1968	Month Year	Day	2b. HOUR 5A M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 1/17/17	6. AGE (In years last birthday) 51 yrs	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Mar. Day 20 Year 1968	2d. HOUR 7A M	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Dorchester	Md.				
10. CITY OR TOWN OF DEATH RD2 Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Restaurant Operator			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 100 Cemetery Ave.				
14. FATHER'S NAME Edgar	First Middle Cannon	Lost	15. MOTHER'S MAIDEN NAME Amelia	First Middle Willey	Lost			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16b. SOCIAL SECURITY NO. WW2	17. INFORMANT Mr Wylie F. Gray Cambridge Md.	ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> DUE TO, OR AS A CONSEQUENCE OF 953 X Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Min.		
(b) <u>Hanging</u> DUE TO, OR AS A CONSEQUENCE OF								
(c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 974 X								
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 5AM 3/20/68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Suicide				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) Restaurant		21f. LOCATION Street or R.F.D. No. State Route 50 Cambridge, Dor. Md.		City or Town	County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John Mace Jr. M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22b. DATE SIGNED 3/21/68	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
ADDRESS (Street, city, town, or county) Cambridge, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/22/68	23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park	23d. LOCATION (City or Town) Cambridge Dorchester Md.	(County)	(State)			
24. FUNERAL DIRECTOR Kenneth L. Thomas Jr.	ADDRESS Cambridge Md.	25a. REC'D BY REGISTRAR MAR 26 1968	25b. REGISTRAR'S SIGNATURE Charles J. Jones					

FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
3/21/68 10:03 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

34020

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF EST. DEATH MATED	Month	Day	Year	2b. HOUR	
Alfred Gordon Corbman						<input type="checkbox"/>	3	13	1968	M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	2c. DATE PRONOUNCED DEAD Month Day Year					
Male	White	April 27 1900	67 YRS.			March 13	1968	10	PM		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Ontario Canada		Canada				Dorchester					
10. CITY OR TOWNS OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge			Cambridge Md. Hosp.			Ship Captain			Shipping		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Maryland			Dorchester		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		103 Choptank Ave.				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Arthur					Corbman	Mingonette					Barker
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No						Mrs. Alfred Corbman 103 Choptank Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Coronary occlusion APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Mins.											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4201			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?		
19c. MEDICAL CERTIFICATION									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			John Mace Jr. M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county)			Cambridge, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town) (County) (State)		
Burial			3/16/68			Dorchester Mem. Park			Cambridge Dorchester Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Kearney R. Shewes Jr.			Cambridge Md.			MAR 18 1968			Charles J. ...		

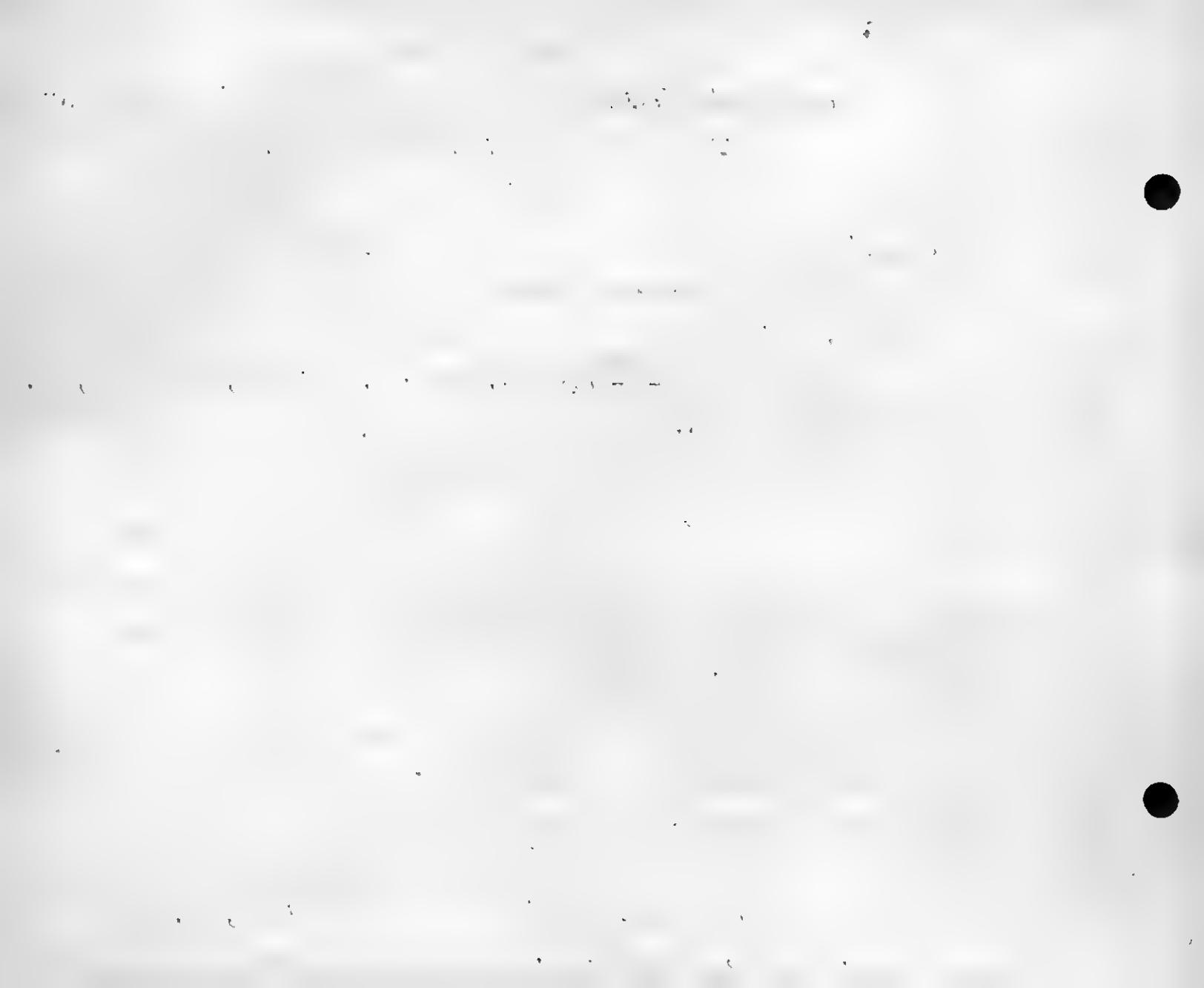
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 04039				1 4821					
1 DECEASED NAME (Type or print)		First	Middle	Last		2a. DATE OF DEATH 3 Month 7 Day 1968 Year 10:57A			
Howard Wesley Farinholt									
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10/1/1892		6 AGE (In years last birthday) 75 YRS.			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester			
10. CITY OR TOWN OF DEATH Rhodesdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RFD		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farming		12b. KIND OF BUSINESS OR INDUSTRY Md.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Rhodesdale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME First Middle Last William H. Farinholt		15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Fach							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 219-36-5123		17. INFORMANT Mrs. Howard W. Farinholt, Rhodesdale, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteric stenosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardio-vascular disease</u>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 2-19, 1968, to 2-28, 1968, that (I) (we) last saw the deceased alive on 2-28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John Francis W.M.</u>								22c. DATE SIGNED 3-19-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS Shipley & Son's Cecil, Delaware					
23a. BURIAL, CREMATION, BURIAL (Specify) Burial		23b. DATE 3/20/1968		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park		23d. LOCATION (City or Town) Baltimore, Md.		(County) (State)	
24. FUNERAL DIRECTOR NEONAM FUNERAL HOME, Sharptown, Md.		ADDRESS		25a. RECEIVED BY REGISTRAR DATE MAR 21 1968		25b. REGISTRAR'S SIGNATURE <u>John Farinholt</u>			



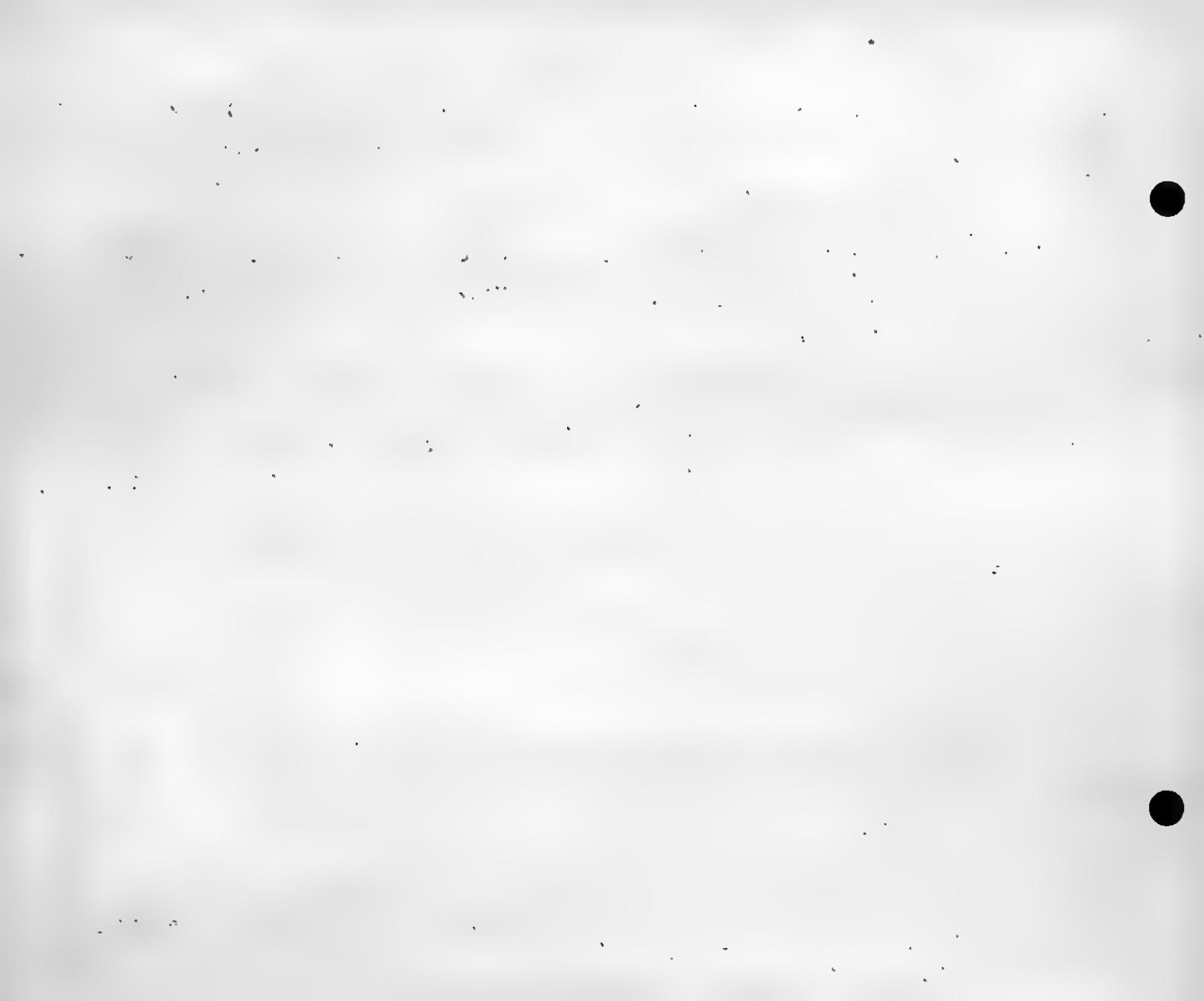
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

0 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M RDCA 18

1. DECEASED-NAME (Type or print)	First Middle Last			2a. DATE OF DEATH	
MARY Gertrude Ford			Month	Day	Year
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last b. day)	
Female	White	5-01-88		79	YRS. MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH
New York	U.S.A.				Dorchester
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
Cambridge	Eastern Shore State		Housewife		Housewife
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER	13f. ADDRESS
Md.	Somerset	Crisfield		R7D CRISFIELD	
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First Middle Lost
Joseph			Cross Mina Cross		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown.)	16b. SOCIAL SECURITY NO		17. INFORMANT		Address
No	UNKNOWN		Medical Records E.S.S. H.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY.					
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <u>2 days.</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Exsanguination of rt. leg -</u> 2 months					
DUE TO, OR AS A CONSEQUENCE: (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 2-15-67, to 3-27-68, that (I) (we) last saw the deceased alive on 3-27-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	22c. DATE SIGNED				
<u>E.C. Fernandez MD</u>		22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS	3-28-68	
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION (City or Town)	(County)	(State)
BURIAL	3-30-68	ST. Paul's CEMETERY CRISFIELD	SOM. MD		
24. FUNERAL DIRECTOR	ADDRESS		25a. REG'D BY REG'STRAR	25b. REGISTRAR'S SIGNATURE	
Loroy Watson	Hinman Funeral Home		APR 2 - 1968	Charles Judge	



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH	Month	Day	Year	2b. HOUR
		John	Wesley	Hall 3rd	ESTI.	MAR.	31	1968	M
3. SEX	4. RACE	5. DATE OF BIRTH	AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	AMM	2c. DATE PRONOUNCED DEAD		
Male	White	March 14, 62	66 yrs				Month	Day	Year
7a. BIRTHPLACE (State or Foreign Country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED NEVER MARRIED WIDOWED DIVORCED		9. COUNTY OF DEATH		2d. HOUR		
Maryland		U.S.			Dorchester		19 M		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
RD 3, Cambridge		Cambridge, Md. - rural			Retired - farmer - self employed				
13a. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) STATE		13b. CITY OR TOWN			13c. STREET AND NUMBER				
Md.		Dorchester Cambridge			Castle Haven Rd., RD 3				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
		Edwin			Barbara	Hammel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
(If yes give war or dates of service)				Mrs. Lorna G. Hall		same address as above			
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) <u>Multiple myocardial scars</u>									
DUE TO, OR AS A CONSEQUENCE OF									
4129									
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last									
(b) <u>Exs. coronary sclerosis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		<u>Peter W. Rieckert</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22b. DATE SIGNED	
EXAMINER'S NAME (Type)		<u>Peter W. Rieckert</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	ADDRESS (Street, city, town, or county)	4-1-68	
23a. BURIAL/CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town)		(County)	(State)
Burial		4/5/68		Druid Ridge Cemetery		Pikesville, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REG STRR		25b. REGISTRAR'S SIGNATURE			
Gerrit L. Thomas Jr. Cambridge Md.				APR 5 - 1968		Charles Judge			
VR A15M (1) 10M REV 1/68									



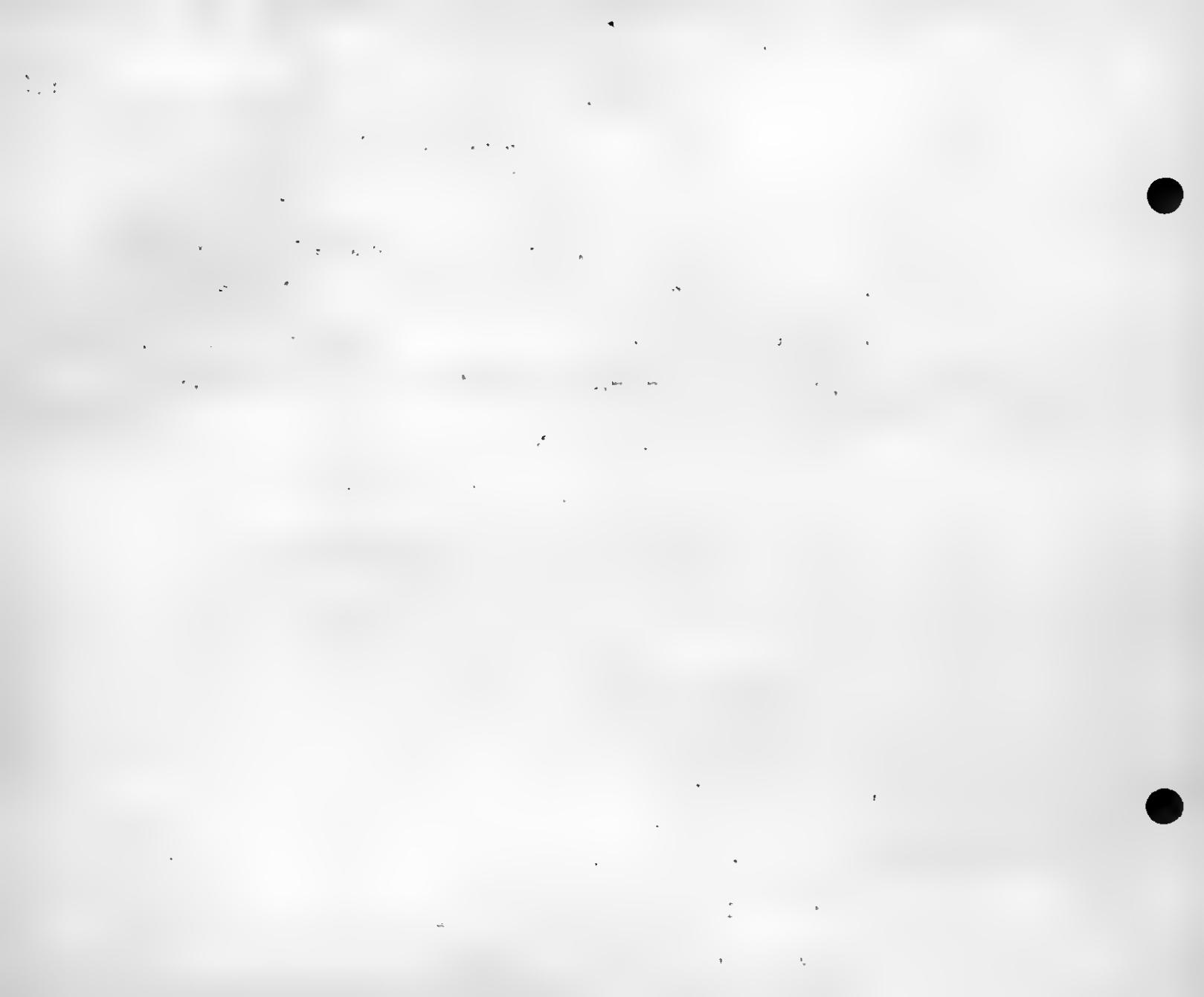
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First DON	Middle A.	Last HUNT	2a. DATE OF DEATH Month March Day 21 Year 1968	6b. HOUR P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Aug. 29, 1919		6. AGE (In years last birthday) 48 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Rural Mail Carrier		12b. KIND OF BUSINESS OR INDUSTRY US Mail
13a. USUAL RESIDENCE (Where deceased lived, if institution Residue before admission) STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Vienna		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Middle Street
14. FATHER'S NAME First Dr. Elwood		Middle V.	Last Hunt	15. MOTHER'S MAIDEN NAME First Elizabeth		Middle ?	Last Higgins
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> or unknown Yes WW II		16b. SOCIAL SECURITY NO 220-01-7296		17. INFORMANT LeCompte Funeral Service records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Esophagus. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months / Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with metastases to lungs. DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
MEDICAL CERTIFICATION	19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
	21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or RFD No. 610	City or Town Cambridge	County Md.	State		
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from 9/24/68 to 3/21/68 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 3/21/68 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) <input type="checkbox"/> view the body after death.							
22b. SIGNATURE <i>Lawrence M. Mazyany</i>		DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3/22/68	
22d. PHYSICIAN'S NAME (Type) LAWRENCE M. Mazyany, M.D.		22e. ADDRESS 610 RACE ST., Cambridge Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar 24, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park		23d. LOCATION (City or Town) Cambridge, Maryland	(County) (State)	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS		25a. REC'D BY REGISTRAR MAR 26 1968	25b. REGISTRAR'S SIGNATURE <i>LeCompte</i>		

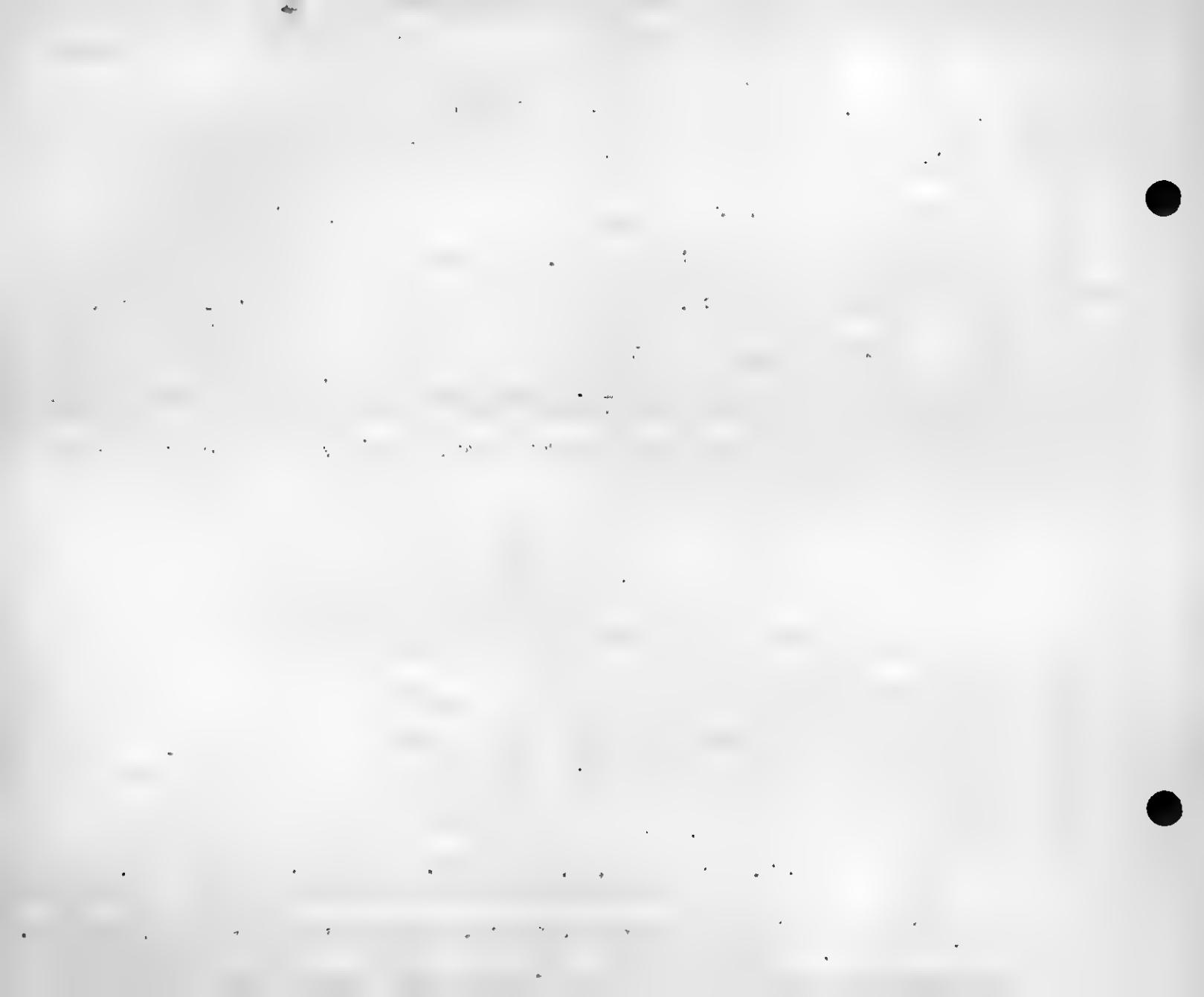


Items 5 & 6 Film 6300
4/5/68 kk 34542
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file page 3 with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED NAME (Type or print)	First Alford	Middle William	Lost Jackson	2a. DATE OF DEATH Month March	Day 25	Year 1968	2b. HOUR 9:30 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH January 15, 1886	6. AGE (In years last birthday) 82	1. UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Dorchester				
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge-Md. Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Dorchester	12b. KIND OF BUSINESS OR INDUSTRY Md				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 608 Academy St.			
14. FATHER'S NAME Samuel	First Middle Jackson	15. MOTHER'S MAIDEN NAME First Middle Lost					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 211-07-9266	17. INFORMANT Mrs. Alford Jackson	Address 608 Academy St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA OF LEFT LUNG</u> 16201 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNDER			
(b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
1. <u>CORONARY HT. DISEASE</u>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <u>3/5</u> , 19 <u>68</u> , to <u>3/25</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/25</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Alfred R. Maryanov</u>	M.D. DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 3/26/68			
22d. PHYSICIAN'S NAME (Type) Alfred R. Maryanov, M.D.	22e. ADDRESS 610 Race St., Cambridge, Md. 21613						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/27/68	23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park	23d. LOCATION (City or Town) Cambridge Dorchester Md.	(County)	(State)		
24. FUNERAL DIRECTOR <u>Kenneth R. Sherry Jr.</u>	ADDRESS Cambridge Md. 21613	25a. RECD BY REGISTRAR APR 1 - 1968	25b. REGISTRAR'S SIGNATURE <u>Franklin Judge</u>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

1. My delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

2. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
Charles Monroe Jenkins						<input type="checkbox"/>	3	12	1968	8 AM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years at birthday)	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS DAYS	9 DEATH MATED				2d HOUR	
Male	Negro	Apr. 3, 1883	84 YRS			<input type="checkbox"/>				11 AM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Dorchester					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hurlock RFD#1			Nr. Elwood			Fireman			Canning		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Md.			Dorchester Hurlock			<input type="checkbox"/> NO <input checked="" type="checkbox"/>			RFD #1		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
James			-	Jenkins		Cassie			-		Lake
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
No			218-05-5201			Mrs. Dorothy Fletcher, Hurlock, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Coronary atherosclerosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Distant											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ last _____ (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
								<input type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town	County	State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		<i>John Mace Jr.</i>			MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)		<i>JOHN MACE JR.</i>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
								ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City or Town)		(County)	(State)	
Burial		3-16-68		Johns Cemetery			Preston, Caroline, Md.				
24. FUNERAL DIRECTOR		ADDRESS						25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
Frampton Funeral Home		Federalsburg, Md.						MAR 14 1968	<i>Charles Judge</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death if necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

34044 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Virginia	Middle Dean	Last Jewell	2a. DATE KNOWN OR ESTI. DEATH MATED	Month 3/6	Day 168	Year ? M	2b. HOUR 2d HOUR 21
3. SEX Female	4. RACE White	5. DATE OF BIRTH Oct. 13, 1905	6. AGE (In years last birthday) 62 YRS	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN	2c. DATE PRONONCED DEAD Month 3 Day 6 Year 1968 3:40 P.M.				
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED W DOWED		9. COUNTY OF DEATH Dorchester		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 208 Choptank Ave., Homemaker			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Reside before admission) Maryland			13c. CITY OR TOWN Dorchester		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 208 Choptank Ave.,			
14. FATHER'S NAME Charles A. Dean			15. MOTHER'S MAIDEN NAME Susan R. Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO			17. INFORMANT Walter H. Jewell, Cambridge, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> + 21. + DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 415										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>John Mace Jr.</i>		EXAMINER'S NAME (Type) John Mace Jr.		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CA. EXAM. NER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Cambridge, Md.				
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 8, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Christ Churchyard		23d. LOCATION (City or Town) (County) (State) Cambridge, Md.				
24. FUNERAL DIRECTOR <i>Jewell R. Johnson</i>		ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR DATE MAR 12 1968		25b. REGISTRAR'S SIGNATURE <i>Charles George</i>				

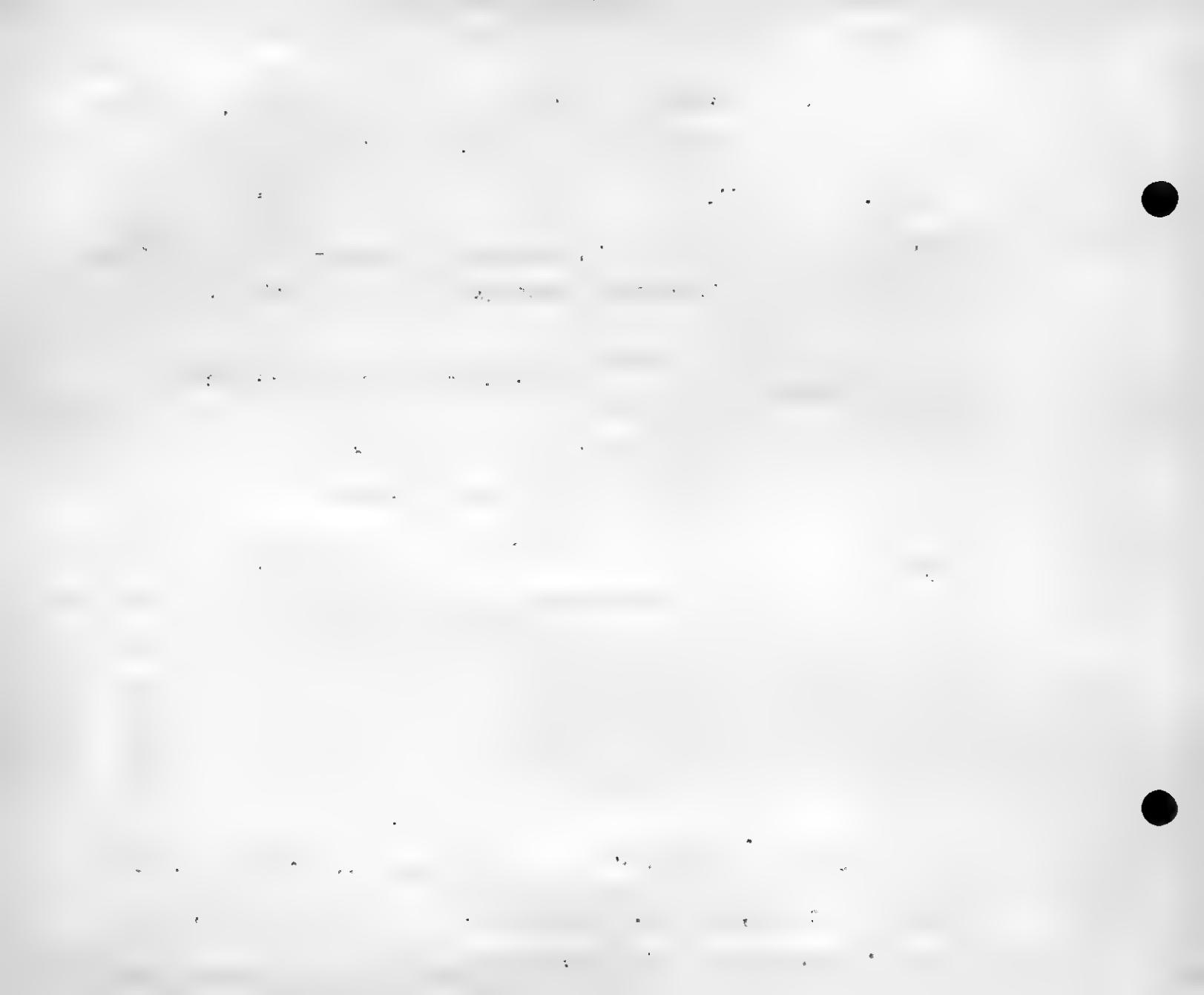


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First J.	Middle WALTER	Lost LASSEN	2a. DATE OF DEATH Month Mar. 14	Day 19	Year 1968	2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Nov. 6, 1888		6. AGE (In years lost birthday) 79 yrs.					
7a. BIRTHPLACE (State or foreign country) Penns.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester					
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Jeweler-Retired			12b. KIND OF BUSINESS OR INDUSTRY Jewelry				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RFD No. 3				
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO WWI		17. INFORMANT LeCompte Funeral Service Records			Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> 4201 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4 (b) <u>Coronary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio Sclerosis</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acu 24 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Methane Gas											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year PM 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.			City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											22c. DATE SIGNED 3/16/68
22b. SIGNATURE <u>James U. Thompson</u>		22d. PHYSICIAN'S NAME (Type) James U. Thompson, MD		22e. DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar 18, 1968		23c. NAME OF CEMETERY OR CREMATORIUM St. Thomas Churchyard		23d. LOCATION (City or Town) White Marsh, Penna.		(County)	(State)		
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 19 1968		25b. REGISTRAR'S SIGNATURE <u>James U. Thompson</u>					



FOR STATE
HEALTH-DEPT.

1
10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained for your files.

2
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI DEATH MATED	Month	Day	Year	2b HOUR
Melvin Richard			Lewis	Jr.	<input checked="" type="checkbox"/>	Mar	9	1968	4:40 PM	
3 SEX	4. RACE	5 DATE OF BIRTH	16 AGE (In years and birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	12c DATE PRONOUNCED DEAD Month	Day	Year	2d HOUR	
Male	White	Jan. 22, 1954	14 yrs			19	19	M		
7a BIRTHPL.ACE (State or foreign country)	7b CIT.ZEN OF WHAT COJNTRY?	8. MARRIED WIDOWED DIVORCED	9 COUNTY OF DEATH							
Md.	U.S.	<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X	Dorchester							
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge										
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER							
Md.	Dorchester	<input checked="" type="checkbox"/> X	704 Academy St.							
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Lost			
Melvin	Richard	Lewis		Pauline			Ball			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS							
NO	(If yes give war or dates of service)	Mrs. Melvin Lewis Cambridge Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ELECTROCUPTION						INSTANT				
9250 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
9140										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOURLY <input type="checkbox"/> 3/9 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)						
CAUSE OF DEATH				STAND LAMP FELL INTO BATHTUB WHILE BATHING						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, offc building, etc.) AT HOME		21f LOCATION Street or RFD No City or Town County State						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Alfred R. Maryanov</i> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <i>ALFRED R. MARYANOV</i>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE SIGNED 3/11/68				
23b DATE 3/12/68						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
23c NAME OF CEMETERY OR CREMATORIAL E. New Market Cemetery						ADDRESS (Street, city, town, or county) 610 Academy St., CAMB DOR				
23d LOCATION (City or Town) E. New Market Dor. Md.						(County) (State)				
24 FUNERAL DIRECTOR <i>Kenneth R. Thomas Jr.</i>						25a REC'D BY REGISTRAR				
ADDRESS Cambridge Md.						25b REGISTRAR'S SIGNATURE <i>Alfred R. Maryanov</i>				
						DATE MAR 14 1968				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14031

TO HOSPITAL OR ATTENDING PHYSICIAN:

The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH 3 Month Day Year	2b. HOUR 11:30 AM M
Manie Lou McAllister				3 10 68	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN
Female	white	3/7/1897	91		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH		
Md.	U.S.A.		Dorchester		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge	Cambridge Hospital	Waitress	Waitress		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
Md	Dor.	Elliott			
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First
Harrison			Horseman	Mary	Gray
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address		
No		Mrs Alonza Gray, Elliott, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pneumonia 4860X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause last. 4961X DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WKS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cardiac decompensation arteriosclerotic heart disease					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Feb. 23, 1968, to March 10, 1968, that (I) (we) last saw the deceased alive on March 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>J. Edwin Fassett</i>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 3/11/68	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS 623 High St Cambridge, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 3/12/68	23c. NAME OF CEMETERY OR GREMATORIAL Elliott	23d. LOCATION (City or Town), (County) Elliott, Dor. Md.		
24. FUNERAL DIRECTOR <i>Death Handling by East End Market</i>	ADDRESS	25a. REC'D BY REGISTRAR DATE MAR 12 1968	25b. REGISTRAR'S SIGNATURE <i>Charles J. Fassett</i>		



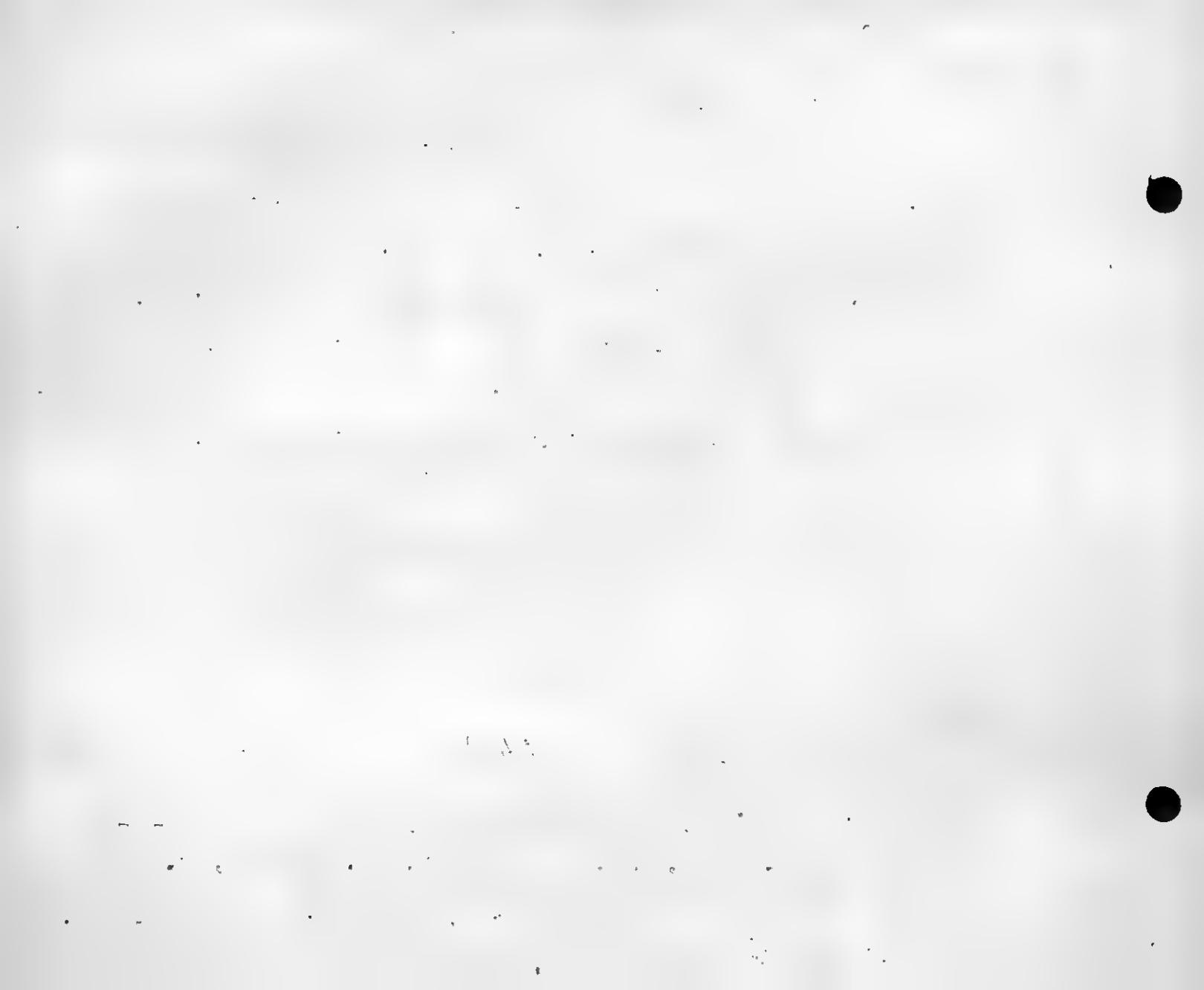
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled 100% the following pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First Ruby	Middle Alice	Last Morgan	2a. DATE OF DEATH Month March	Day 10	Year 1968	2b. HOUR 4 A M	
3 SEX Female	4. RACE White	5. DATE OF BIRTH 1/13/1917	6. AGE (In years (last birthday) 51	7. IF UNDER MONTHS YRS	8. IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Dorchester					
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge-Md. Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Hairdresser	12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institutional: Residence before admission) STATE Md.	13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 203 Henry St.				
14. FATHER'S NAME First Arthur	Middle H.	Last Hughes	15. MOTHER'S MAIDEN NAME First Minnie	Middle V.	Lost	16. ADDRESS Cambridge Md.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Mrs. Russell Brannock						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS WITH MYOCARDIAL INFARCTION</u> 7/15 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF AND CONGESTIVE FAILURE								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. col. examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>3-4-68</u> , 19 <u>68</u> , to <u>3-10-68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3-9-68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Albert E. Bunker, M.D.</u>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>3-11-68</u>			
22d. PHYSICIAN'S NAME (Type) Albert E. Bunker, M. D.		22e. ADDRESS 200 Md. Ave., Cambridge, Md. 21613						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/12/68	23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park			23d. LOCATION (City or Town) Cambridge	(County) Dor.	(State) Md.
24. FUNERAL DIRECTOR <u>Kenneth Thomas Jr.</u>		ADDRESS Cambridge Md. 21613			25a. REC'D. BY REGISTRAR MAR 15 1968	25b. REGISTRAR'S SIGNATURE <u>Frederick</u>	DATE	



1
34049
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH
34033

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First GLADYS	Middle EDNA	Last MURPHY	2d. DATE OF DEATH Month Mar. Day 29 Year 1968	2b. HOUR 11 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH Dec. 12, 1897		6. AGE (In years lost birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Dorchester		
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY HOME
13a. USUAL RESIDENCE (Where deceased lived if institution Res dence before admission) STATE Md.	13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 209 Virginia Avenue	
14. FATHER'S NAME First William Middle ? Last Mackins	15. MOTHER'S MAIDEN NAME First Anne Middle ? Last Woodland				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. unk	17. INFORMANT LeCompte Funeral Service records	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Recurrent squamous cell carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 100X of cervix with metastases				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1/18					
19a. DATE OF OPERATION 3/18/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Biopsy of cervix	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (1) (this hospital) attended the deceased from March 19, 1968 to Mar 29, 1968 , that (1) (we) last saw the deceased alive on Mar 29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Lewis M. Burdette	22c. DEGREE ATTENDING PHYS.	22d. ADDRESS 4 Aurora St. Cambridge, Md.	22e. DATE SIGNED 3/30/68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Mar 31, 1968	23c. NAME OF CEMETERY OR CREMATORIAL East New Market Cemetery	23d. LOCATION (City or Town) East New Market, Maryland	(County)	(State)
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland	ADDRESS	25a. REC'D BY REGISTRAR APR 3 - 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												34	
1 DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- MATED			Month	Day	Year	2b. HOUR	
MARGARET COLLINS PHILLIPS						<input type="checkbox"/> Mar. 11			19	68	2:20 P.M.		
3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (in years last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d. HOUR				
Female	White	Oct. 12, 1923	44 yrs	MONTHS	DAYS	HOURS	MIN	Month	Day	Year			
7a. BIRTHPL. ACE (State or foreign country)		7b. C. T. ZEN OF WHAT COUNTRY?		8	MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH				
New York		USA							Dorchester				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Cambridge			Cambridge Md. Hospital			Housewife			Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER					
Md.			Dorchester			Fishing Creek	<input type="checkbox"/> NO <input checked="" type="checkbox"/>	None					
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
Roy ? Collins						Minnie					McNellte		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT			ADDRESS				
No			unk			LeCompte Funeral Service records							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cardiac arrest												Instant	
DUE TO, OR AS A CONSEQUENCE OF													
Conditions if any which gave rise to immediate cause (a) stating the underlying cause last													
(b) General peritonitis												2 days	
DUE TO, OR AS A CONSEQUENCE OF													
(c) Perforated ileum												2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
578X			19a. DATE OF OPERATION 3/11/68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED General Peritonitis			20. AUTOPSY?				
19c. MEDICAL CERTIFICATION									<input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town	County	State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												22b. DATE SIGNED 3/14/68	
ACTUAL SIGNATURE John Nace Jr. M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county) Cambridge, Md.				
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE Mar 16, 1968			23c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park			23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland				
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland			ADDRESS			25a. REC'D BY REGISTRAR DATE MAR 19 1968			25b. REGISTRAR'S SIGNATURE Charles Judge				
VR A SME (5) 10M REV 1-68													



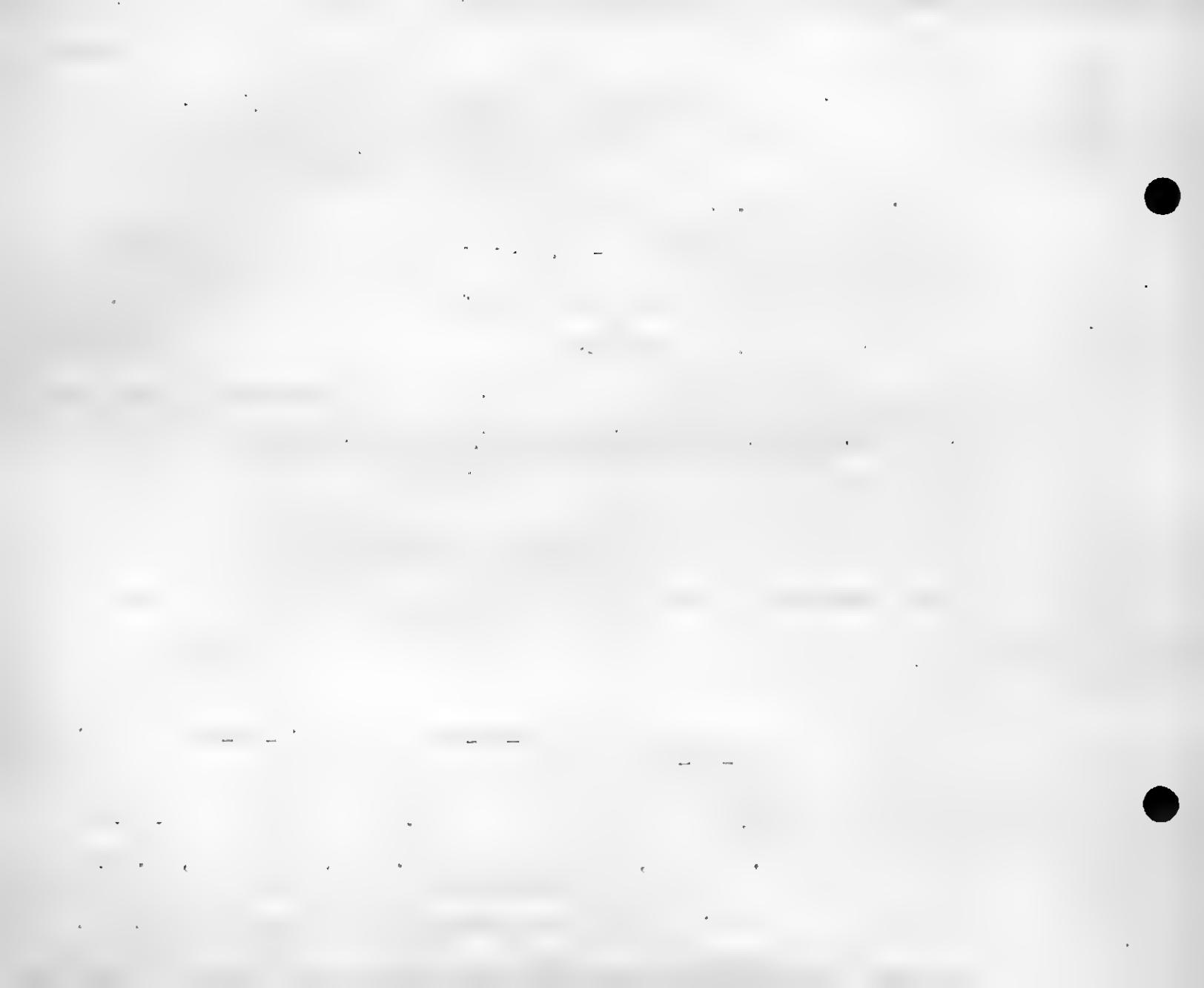
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED-NAME (Type or print)	First		Middle	Lost	2a. DATE OF DEATH	Month		Day	Year	2b. HOUR
Elsie		Daisy		Robinson	March		18	1968		
3. SEX	4 RACE		S. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UND. 1 YEAR		IF UND. 24 MRS.	
Female	White		12 Feb 1899		78		MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Dorchester			
Maryland	U.S.									
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPAT. ON (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge	Cambridge-Md. Hospital		Homemaker							
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE	13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		Md.			
Maryland	Dorchester		Cambridge	X	420 Robbins St.					
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Last			
George	D.	Taylor		Moszellias			Neighbors			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO		17. INFORMANT		Address					
No			Mrs. Daisy Wheatley Cambridge Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary thrombosis with myocardial infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) _____ stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from 8-25-52, 19, to 3-18-68, 19, that (I) (we) last saw the deceased alive on 3-18-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.										
22b. SIGNATURE <i>Albert E. Bunker MD</i>	DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 3-19-68					
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS		200 Md. Ave., Cambridge, Md. 21613							
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION (City or Town)		(County)		(State)		
Burial	20 Mar 1968	Greenlawn Cemetery		Cambridge Dor. Md.						
24. FUNERAL DIRECTOR <i>Reneeth R. Thorpe</i>	ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
Cambridge Md.		DATE MAR 22 1968								



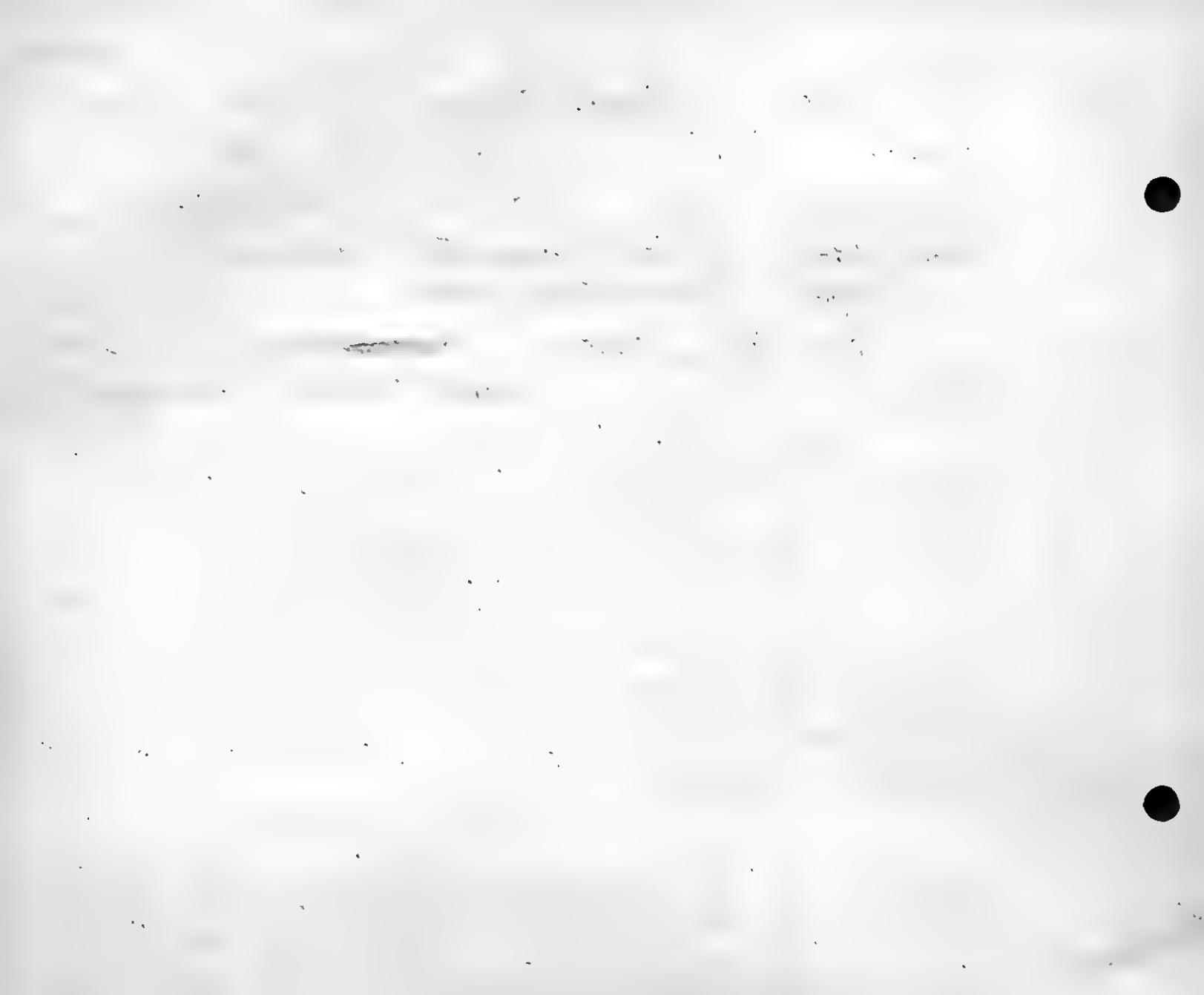
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>Lettie</i>	Middle <i>Moore</i>	Lost <i>Robinson</i>	2a. DATE OF DEATH Month <i>March</i>	Day <i>2</i>	Year <i>1968</i>	2b. HOUR <i>7:45 AM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>	5. DATE OF BIRTH <i>9-10-89</i>		6. AGE (In years lost birthday) <i>78</i>		7. IF UNDER 1 YEAR MONTHS <i>0</i>		8. IF UNDER 24 HRS. HOURS <i>7</i>		
7a. BIRTHPLACE (State or foreign country) <i>Delaware</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Dorchester</i>					
10. CITY OR TOWN OF DEATH <i>Cambridge</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Eastern Shore State</i>		12a. OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Somerset</i>		13c. CITY OR TOWN <i>Jamesport</i>		13d. INSIDE CITY LIMITS <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First <i>John</i>		Middle <i>M. C.</i>	Lost <i>Moore</i>	15. MOTHER'S MAIDEN NAME First Middle <i>Carrey</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (Unknown) <i>No</i>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <i>Hospital Record</i>		Address <i>Cambridge, Md.</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Pruritic CVA</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized arteriosclerosis</i>		DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>Chronic Brain Syndrome</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. <i>1</i>		City or Town <i>Cambridge</i>		County <i>Somerset</i>		State <i>Md.</i>	
22a. I certify that <i>(I)</i> (this hospital) attended the deceased from <i>1-29-1968</i> to <i>3-2-1968</i> , that <i>(I)</i> (we) last saw the deceased alive on <i>3-1-1968</i> , and that in <i>(my)</i> (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above, <i>(I)</i> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Edward Lewis</i>		22c. DEGREE ATTENDING PHYS. <input type="checkbox"/>		22d. MED. DIRECTOR <input type="checkbox"/>		22e. STAFF PHYS. <input checked="" type="checkbox"/>		22f. DATE SIGNED <i>3-2-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>EDWARD LEWIS, MD</i>		22e. ADDRESS <i>ESSH, CAMBRIDGE, MD.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>3/5/68</i>		23b. DATE <i>3/5/68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Chance Cemetery</i>		23d. LOCATION (City or Town) <i>Chance</i>		(County) <i>MD</i>		(State)	
24. FUNERAL DIRECTOR <i>Levin P. Wilson</i>		ADDRESS - <i>Princes Anne</i>		25a. REC'D. BY REGISTRAR <i>MAR 5 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

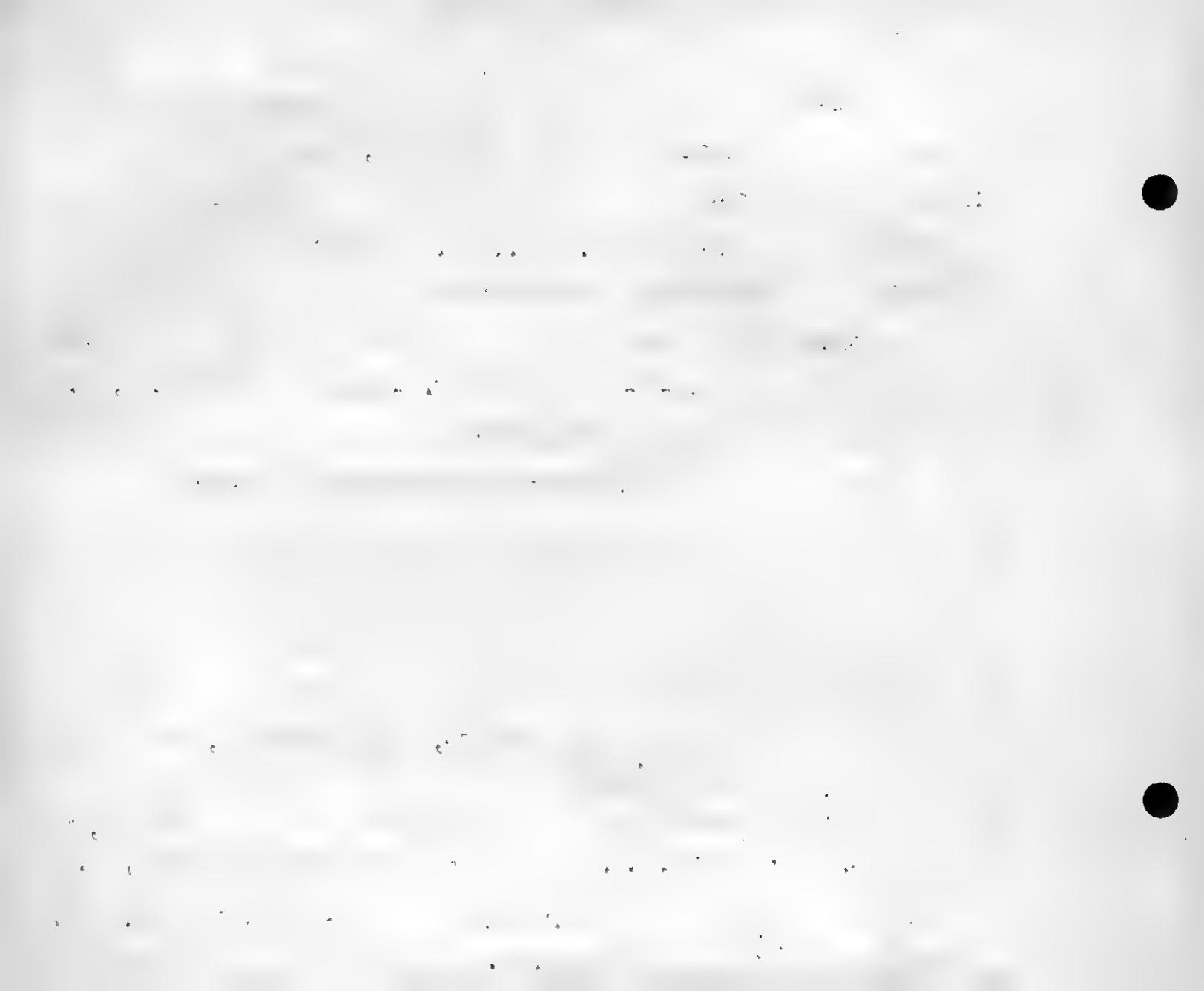


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	2b. HOUR
NETTIE				ROSS	MARCH 28	1968
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	
FEMALE		NEGROID	DECEMBER 28, 1914		53 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
MARYLAND		USA			DORCHESTER	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
CAMBRIDGE		CAMBRIDGE MD. HOSP., INC.		LABORER		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	
MARYLAND		DORCHESTER	HOOPERSVILLE	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	HOOPERSVILLE	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	Address
		WILLIAM	BAILEY	ROSS	IDA	HOOPERSVILLE, MD.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		
NO		217-03-5223		JAMES C. JOHNSON		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		CARDIAC DECOMPENSATION				
41d0		DUE TO, OR AS A CONSEQUENCE OF				
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last.		(b) ARTERIOSCLEROTIC CARDIOVASCULAR RENAL DISEASE				
		DUE TO, OR AS A CONSEQUENCE OF				
		(c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from OCT 19, 1967, to MARCH 28, 1968, that (I) (we) last saw the deceased alive on MARCH 28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE		22c. DATE SIGNED				
<i>Edwin Fassett</i>		MARCH 29, 1968				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
J. EDWIN FASSETT, M.D.		623 HIGH STREET		CAMBRIDGE, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3/31/68	23c. NAME OF CEMETERY OR CREMATORIUM ST. PETERS		23d. LOCATION (City or Town) MEEKINS NECK	(County) (State) DOR. MD.
24. FUNERAL DIRECTOR		ADDRESS CAMBRIDGE, MD.	25a. REC'D BY REGISTRAR APR 24 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of the death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2 may be referred to your lawyer.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

1. DECEASED NAME (Type or Print) FRANK EDWARD SEABREASE				First	Middle	Last	2a DATE KNOWN OF EST- DEATH MATED	Month	Day	Year	2b HOUR 9 P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH Feb. 6, 1893	6 AGE (In years last birthday) 75	7 IF UNDER 1 YEAR MONTHS YRS	8 IF UNDER 24 HRS HOURS MIN	9 DATE PRONOUNCED DEAD Month March	10 Year 12 1968	11 2d HOUR 9 P M			
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Dorchester		Md			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge-Maryland Hospital				12a USUAL OCCUPATION (Kind of work done during past 6 months, even if retired) Huckster				12b KIND OF BUSINESS OR INDUSTRY Vegetable	
13a USUAL RESIDENCE (Where deceased lived, if institution admiss on) STATE Maryland		13b CITY OR TOWN Dorchester		13c CITY OR TOWN Hurlock		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME Richard F. Seabrease		15. MOTHER'S MAIDEN NAME Emma Wise				16. PARENT'S FIRST MIDDLE LAST					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIA. SECURITY NO 220-52-7895		17. INFORMANT Mrs. Margaret Seabrease, Hurlock, Maryland		18. ADDRESS Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 427.0											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4341											
20. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) P.M.							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town	County	State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Mace Jr.</i>		EXAMINER'S NAME (Type) John Mace Jr. M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 3/14/68			
EXAMINER'S NAME (Type)		ADDRESS (Street, city, town or county) Cambridge, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
230 BURIAL CREMATION, REMOVAL (specify) Burial		23b DATE March 18, 1968		23c NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery		23d LOCATION (City or Town) Baltimore, Maryland		(County) (State)			
24 FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS		25d REC'D BY REG STRAR DATE MAR 19 1968		25d REGISTRAR'S SIGNATURE <i>Charles George</i>					

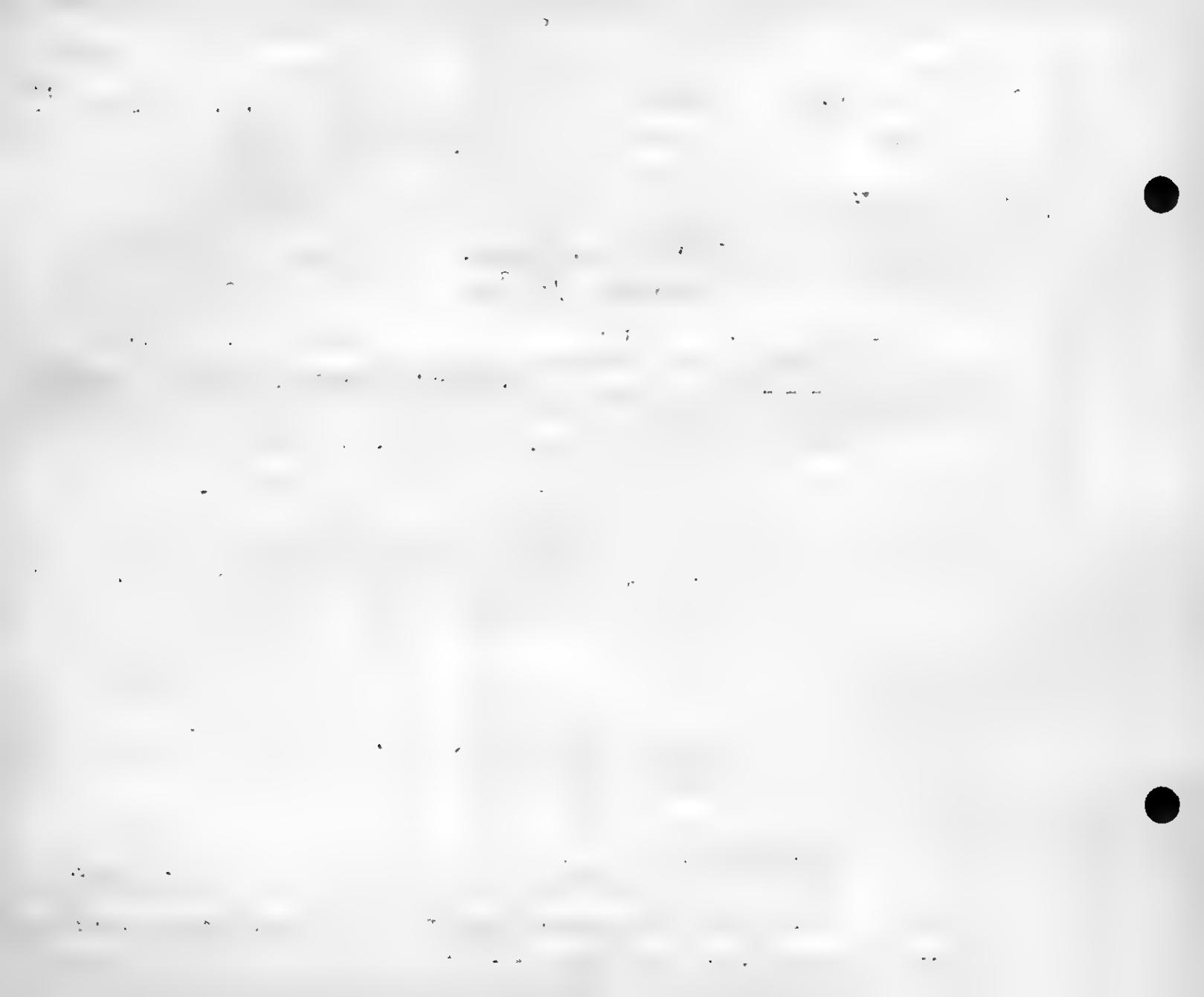


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First ROSIE	Middle BENNETT	Last SEWARD	2a. DATE OF DEATH Month Mar.	Day 4	Year 1968	2b. HOUR 8:45 p.m.			
3. SEX Female		4. RACE White	5. DATE OF BIRTH Oct. 17, 1897			6. AGE (In years lost birthday) 70 yrs.			IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Dorchester						
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Dorchester		13c. CITY OR TOWN RFD #3 Cambridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RFD #3				
14. FATHER'S NAME First Thomas		Middle E.	Last Bennett	15. MOTHER'S MAIDEN NAME First Susie			Middle ?	Last Rhea				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO unk		17. INFORMANT Mr. Eldridge Wheatley, Cambridge, MD			Address Mr. Eldridge Wheatley, Cambridge, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 12 hrs. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) CORONARY HT. DISEASE 3 yrs. DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) PANOXYSMOL VENTRICULAR TACHYCARDIA												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 2/3, 1968 , to 3/4, 1968 , that (I) (we) last saw the deceased alive on 3/4, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.												
22b. SIGNATURE Alfred R. Maryanov MD		22c. DATE SIGNED 3/5/68		22d. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e. ADDRESS 610 Race St. Cambridge, MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar 7, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Dail Family Cemetery		23d. LOCATION (City or Town) RFD #3, Cambridge, Maryland		(County)		(State)		
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR Charles J. Judge		25b. REGISTRAR'S SIGNATURE Charles J. Judge						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

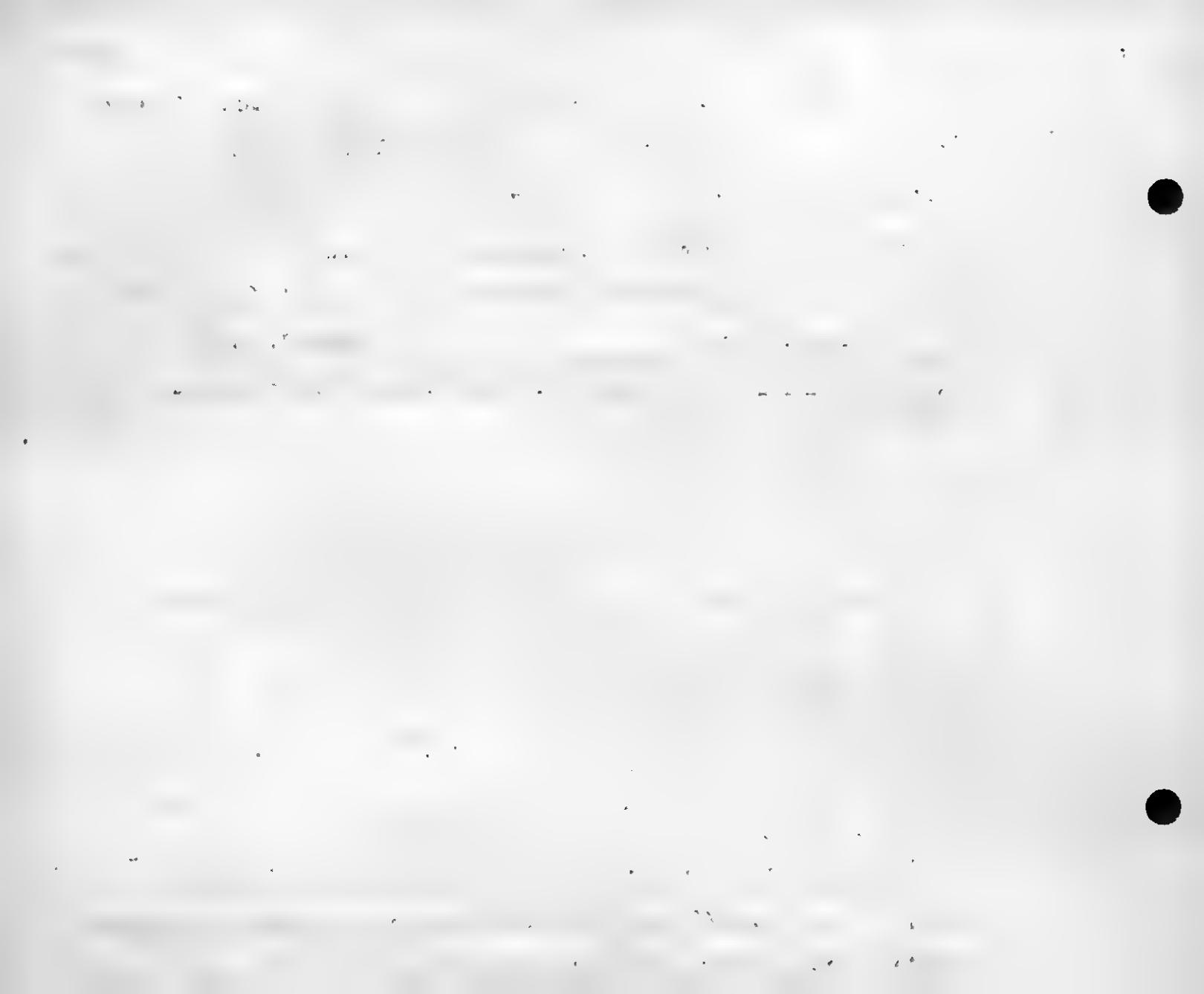
34056

110-11

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. In any event, within 72 hours after death, this certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First CORA	Middle J.	Lost	2a. DATE OF DEATH Month Mar. 17	Year 1968	2b. HOUR M
3. SEX Female		4 RACE White	5. DATE OF BIRTH March 23, 1891		6. AGE (In years lost birthday) 76		F UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Dorchester		
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md		13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 711 Locust Street	
14. FATHER'S NAME First Marion H. Marshall		Middle	Lost	15. MOTHER'S MAIDEN NAME First Sarah J. Peters		Middle	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO - - -		17. INFORMANT unk		Address LeCompte Funeral Service Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/4 days 410.7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>March 3, 1968</u> , to <u>Mar. 17, 1968</u> , that (I) (we) last saw the deceased alive on <u>Mar. 17, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John Mace Jr.</i>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 3/18/67		
22d. PHYSICIAN'S NAME (Type) John Mace Jr. Md.		22e. ADDRESS 604 Church St. Cambridge, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar 20, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park		23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland		
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland				ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>
						DATE MAR 26 1968	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>Lizzie</i>	Middle <i>H.</i>	Lost <i>Stewart</i>	2a. DATE OF DEATH Month <i>March</i>	2b. HOUR <i>6:30 P.M.</i>
3. SEX <i>Female</i>		4. RACE <i>Negro</i>	5. DATE OF BIRTH <i>12-96-?</i>		6. AGE (in years last birthday) <i>71 1/2 yrs.</i>	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		9. COUNTY OF DEATH <i>Laborchester</i>	
10. CITY OR TOWN OF DEATH <i>Rural Lymbridge</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Lister Shores & lot hosp. Lymbridge</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Waitress</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Laundries</i>
13a. USUAL RESIDENCE (Where deceased admission) STATE <i>Md.</i>		13b. COUNTY <i>T. H. C.</i>	13c. CITY OR TOWN <i>Boston</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES	13e. STREET AND NUMBER <i>125-P St. St.</i>	
14. FATHER'S NAME First <i>D. Rose</i>		Middle <i>Perry</i>	15. MOTHER'S MAIDEN NAME First <i>Rosie</i>	Middle <i>Perry</i>	Lost <i>Perry</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Unknown</i>		16b. SOCIAL SECURITY NO <i>213-229-2330</i>	17. INFORMANT <i>Met Recently</i>	Address <i>125-P St. St. Hospital</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>41</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Arteriosclerotic Heart Disease</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Years -</i>		
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>CHRONIC BRAIN SYNDROME ASS. cerebral arteriosclerosis without qualifying</i>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> NO		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year P.M. <input type="checkbox"/> 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. <input type="checkbox"/> City or Town <input type="checkbox"/> County <input type="checkbox"/> State				
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>1-16</i> , 19 <i>68</i> , to <i>3-31</i> , 19 <i>68</i> , that <input type="checkbox"/> (we) lost saw the deceased alive on <i>3-31</i> , 19 <i>68</i> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.						
22b. SIGNATURE <i>John J. Sperry Jr.</i>		DEGREE <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR	22c. DATE SIGNED <i>4-1-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>FELIPE M. DOMINGUEZ, M.D.</i>	22e. ADDRESS <i>ESS. H. -</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>April-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Boston Cem.</i>	23d. LOCATION (City or Town) <i>Boston</i>	(County) <i>Ta</i>	(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>George H. Deaklin Entwistle</i>	ADDRESS	25a. REC'D BY REGISTRAR <input type="checkbox"/> DATE <i>APP 10 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

5-255

4042

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month	3	Day	3	Year	68	2b. HOUR
<i>Beulah Bradley Trice</i>						Month	3	Day	3	Year	68	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS		8. IF UNDER 24 HRS. DAYS		9. IF UNDER 24 HRS. HOURS
Female		White		4/22/1886		81		YRS.				MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. COUNTY OF DEATH						
Md.		U.S.A.		<input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED		Dorchester						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge			Cambridge Md.			None						
13a. USUAL RESIDENCE (Where deceased admission) STATE		lived, if institution Residence before		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
Md		Dor		Hurlock		NO						
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			Middle			Last
Zachariah W. Bradley						Sophia Pattison						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
NO			—			Mrs James Nichols, Hurlock, Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>												8 HRS.
410.4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) <i>ARTERIOSCLEROTIC HEART DISEASE</i>												5-10 YRS.
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
<i>BILATERAL BRONCHOPNEUMONIA</i>												
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
								YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>FEB 3, 1968</i> to <i>MARCH 3 1968</i> , that (I) (we) lost saw the deceased alive on <i>MARCH 2 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do not) (do not) view the body after death.												
22b. SIGNATURE <i>Donald R. McWilliams</i>												22c. DATE SIGNED <i>3/4/68</i>
22d. PHYSICIAN'S NAME (Type) Donald R. McWilliams, M.D.		22e. ADDRESS P.O. Box 248, East New Market, Md. 21631										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>3/5/68</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Washington</i>		23d. LOCATION (City or Town) (County) (State) <i>Hurlock Dor Md</i>						
24. FUNERAL DIRECTOR		25. ADDRESS <i>Funeral Parlor by East New Market</i>		25a. REC'D BY REGISTRAR NAME <i>Wm. H. Williams</i>		25b. REGISTRAR'S SIGNATURE DATE <i>1968</i>						



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the funeral director. Page 4 should be used as a burial-transit permit. File pages 1 and 2 with the Chief Medical Examiner's Office. Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)	First Michael	Middle Bruce	Last Vincent	2a. DATE KNOWN OF ESTI. DEATH MATED Month March	Day 23	Year 1968	2b. HOUR 4 P M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 2/2/55	6. AGE (in years last birthday) 13 yrs.	F. UNDER 1 YEAR MONTHS MONTH	I. F. UNDER 24 HRS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month March	2d. HOUR 23 Year 1968	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED WIDOWED DIVORCED	9. COUNTY OF DEATH Dorchester	Md.				
10. CITY OR TOWN OF DEATH Woolford	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Deep Point			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) School			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13c. CITY OR TOWN Dorchester	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Laurie Lane					
14. FATHER'S NAME Roland	First E.	Middle Vincent	Last Sarah	15. MOTHER'S MAIDEN NAME Price				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Mr. Roland E. Vincent Woolford Md.	ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Strangulation</u> DUE TO, OR AS A CONSEQUENCE OF 953 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant	
(b) <u>Hanging</u> DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a) 974 X								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR <input type="checkbox"/> 1:30 P.M. 3/23/68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Hanged self with belt.				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No Woolford, Dorchester, Md.	City or Town Woolford, Dorchester, Md.	County Dorchester	State Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John Mace Jr. M.D.		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 2/25/68		
EXAMINER'S NAME (Type) John Mace Jr. M.D.		MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county) Cambridge, Md.								
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE 3/26/1968	23c. NAME OF CEMETERY OR CEMATDRY Dorchester Mem. Park	23d. LOCATION (City or Town) Cambridge Dorchester Md.	(County) Cambridge	(State) Md.	23e. REG'D BY REGISTRAR APR 1 - 1968		
24. FUNERAL DIRECTOR Frederick R. Thomas		ADDRESS Cambridge Md.	25b. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper from page 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED NAME (Type or print)		First <i>Naomi</i>	Middle <i>Ford</i>	Last <i>Walston</i>	2a. DATE OF DEATH Month <i>3</i>	Day <i>27</i>	Year <i>68</i>	2b. HOUR <i>4:30 AM</i>							
3. SEX <i>Female</i>		4. RACE <i>white</i>	5. DATE OF BIRTH <i>6-25-1888</i>		6. AGE (in years last birthday) <i>79 yrs.</i>		7. UNDER 1 YEAR MONTHS <i>0</i>		8. UNDER 24 HRS. HOURS <i>0</i>						
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Dorchester</i>		10. CITY OR TOWN OF DEATH <i>Cambridge</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Eastern Shore State Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) <i>MARYLAND</i>		13b. CITY OR TOWN <i>Somersett</i>		13c. INSIDE CITY LIMITS? <i>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></i>		13d. STREET AND NUMBER <i>Fairmount</i>		14. FATHER'S NAME First <i>Oliver</i>		Middle <i>Ford</i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Emma</i>		Middle <i></i>	Last <i>Ford</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <i>NONE listed</i>		Address <i>Eastern Shore State Hosp (Medical Record)</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF <i>Bronchopneumonia</i>		10 days											
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. <i>5+11</i>		(b) <i>Emphysema, fibrosis</i>		several years											
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>atherosclerotic Heart disease, chronic brain syndrome</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State							
22a. I certify that (I) (this hospital) attended the deceased from <i>9/1/10/1966</i> to <i>3/27/1968</i> , that (I) (we) last saw the deceased alive on <i>3/27/1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Faruk Ozer, M.D.</i>		DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>3/27/68</i>												
22d. PHYSICIAN'S NAME (Type) <i>FARUK OZER</i>		22e. ADDRESS <i>Eastern Shore Hospital Cambridge, Md.</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/30/68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Fairmount Cemetery, Fairmount, Somerset Co. Md.</i>		23d. LOCATION (City or Town) (County) (State)									
24. FUNERAL DIRECTOR <i>James L. Hinman</i>		ADDRESS <i>Funeral Home</i>		25a. REC'D BY REGISTRAR <i>APR 1 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles George</i>									



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	2b. HOUR		
Mildred Geraldine Ward						3 Month 24 Day 68 Year	9:30 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)			
F		W.		03-13-01		67 YRS			
7. BIRTHPLACE (State or foreign country)		8. CITIZEN OF WHAT COUNTRY?		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY			
York Pa.		U.S.A.		Dorchester		Own Home			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			
Cambridge		Eastern Shore State Hosp.				Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Worcester Girdletree		YES <input type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
James		E	M	Metzel	Mary	Ellen	Billet		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		None		Eastern Shore State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) PNEUMONITIS									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)									
DUE TO, OR AS A CONSEQUENCE OF									
last, 49 x									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
GENERALIZED ATHEROSCLEROSIS + CHLOR. BRAIN SYND.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town	County	State
While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (this hospital) attended the deceased from 1-5-1968 to 3-24-1968, that (I) (did) last saw the deceased alive on 3-24-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE									
Edward Lewis MD DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. DATE SIGNED 3-24-68									
22d. PHYSICIAN'S NAME (Type) EDWARD LEWIS M.D 22e. ADDRESS ESS H. Cambridge, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL SERVICE		23d. LOCATION (City or Town)		(County) (State)	
Burial		Mar. 27, 1968		Moreland Memorial Park		Baltimore, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Edward F. Dennis		Snow H. Miller		MAR 26 1968		James J. Dennis			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

1

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First	Middle	Lost	20. DATE KNOWN OF DEATH ESTIMATED	Month	Day	Year	2b HOUR	
William Donald Wheatley					<input checked="" type="checkbox"/>	3	4	1968	8:45 AM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	8 IF UNDER 24 HRS MONTHS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year				2d HOUR
Male	White	7/7/1909	38			3	4	1968	8:45 PM	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester				
10. CITY OR TOWN OF DEATH Secretary		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mfr. Continental Can Co.				12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Res. before admission) STATE Md.		13b. COUNTY Dor		13c. CITY OR TOWN Secretary		13d. INSIDE/OUTSIDE LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First		Middle	Lost	15. MOTHER'S MAIDEN NAME First		Middle	Lost	16. ADDRESS Mrs. W. Donald Wheatley, Secretary, Md.		
William T. Wheatley				Lottie				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs		
16a. WAS DECEASED EVER IN US. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO (Type give war or dates of service) 212-03-2005		17. INFORMANT						
18. CAUSE OF DEATH (Enter only one cause per PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF (d)		Coronary occlusion								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 420!										
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town				County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE John Mace Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) John Mace Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22b. DATE SIGNED 3/5/68										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/7/68		23c. NAME OF CEMETERY OR CREMATORIAL East New Market		23d. LOCATION (City or Town) East New Market, Dor. MD		(County)	(State)	
24. FUNERAL DIRECTOR John D. Willoughby, East New Market		ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 7 1968		25b. REGISTRAR'S SIGNATURE John D. Willoughby				



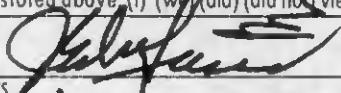
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

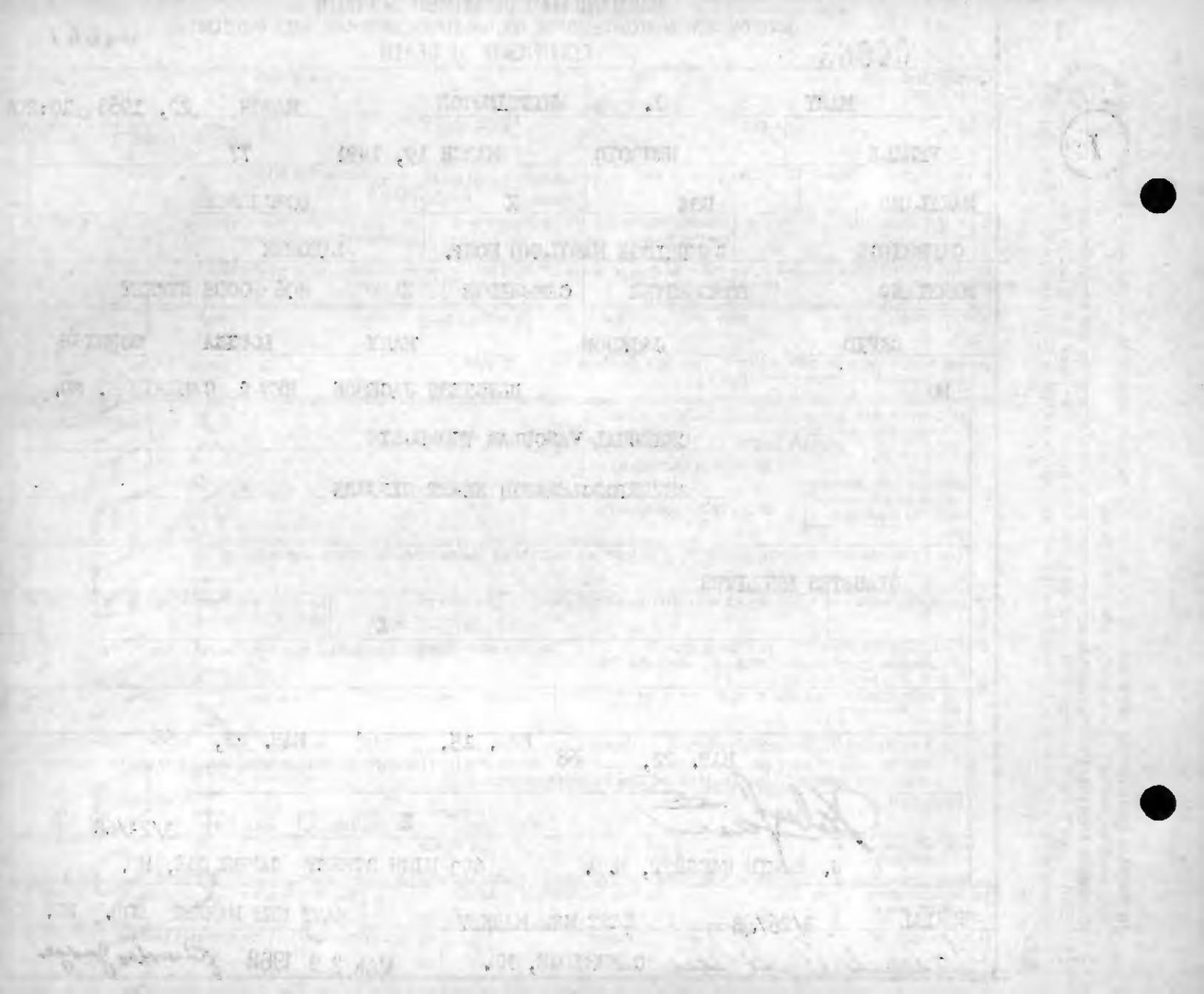
CERTIFICATE OF DEATH

34647

04063

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Please sign and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First MARY	Middle L.	Last WHITTINGTON	2a. DATE OF DEATH Month MARCH	Day 22	Year 1968	2b. HOUR 10:20A
3. SEX FEMALE	4. RACE NEGROID	5. DATE OF BIRTH MARCH 19, 1891		6. AGE (In years last birthday) 77	IF UNDER 1 YEAR MONTHS	IF UNDER 24 MRS. DAYS	IF UNDER 24 HRS. HOURS
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH DORCHESTER			
10. CITY OR TOWN OF DEATH CAMBRIDGE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CAMBRIDGE MARYLAND HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND	13b. COUNTY DORCHESTER	13c. CITY OR TOWN CAMBRIDGE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 806 WOODS STREET			
14. FATHER'S NAME DAVID	Middle JACKSON	Last	15. MOTHER'S MAIDEN NAME MARY	Middle LOUISE	Last CORNISH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO.	17. INFORMANT ULYSSESS JACKSON	Address RFD 2 CAMBRIDGE, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR THOMBOSIS</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4129</u> (b) <u>ARTERIOSCLERATIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4210 DIABETES MELLITUS</u>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from MAR. 15, 1968, to MAR. 22, 1968, that (I) (we) last saw the deceased alive on MAR. 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 	DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3/23/68			
22d. PHYSICIAN'S NAME (Type) J. EDWIN FASSETT, M.D.	22e. ADDRESS 623 HIGH STREET CAMBRIDGE, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 3/26/68	23c. NAME OF CEMETERY OR CREMATORIAL EAST NEW MARKET	23d. LOCATION (City or Town) (County) (State) EAST NEW MARKET DOR. MD.				
24. FUNERAL DIRECTOR 	ADDRESS CAMBRIDGE, MD.	25a. REC'D BY REGISTRAR DATE MAR 29 1968	25b. REGISTRAR'S SIGNATURE 				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month	3 Day	30 Year	68	2b. HOUR A.M.
Rena Lankford Wilkins						3	30	68		
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 MRS. DAYS	IF HOURS	MIN.	
Female	White	07-09-86			81					
7b. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Maryland	U.S.A.				Dorchester					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge	Eastern Shore State			Teacher			Teacher			
13a. USUAL RESIDENCE (Where deceased admission) STATE	13b. CITY OR TOWN			13d. INSIDE CITY LIMITS?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER				
MD.	Wic. Salisbury			YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	505 S. Poplar Hill.				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last			
Benjamin Lankford				Minnie Travers Lankford						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
	_____			Eastern Shore State Hosp. Comb. md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>										16 days
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Arteriosclerosis w/</i>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4500</i>										
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Brain Syndrome</i>										2 mos
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<i>Bilateral Varotitis - Pusitis - Encephalitis -</i>										
19a. MEDICAL CERTIFICATION	19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.			City or Town	County	State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>2-1-68</i> , to <i>3-30-68</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>3-30-68</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.										
22b. SIGNATURE <i>Edward Lewis MD</i>										
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS			22f. DATE SIGNED						
EDWARD LEWIS MD	ESSH, Cambridge, Md.			3-30-68						
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town)	(County)	(State)			
BURIAL	4-1-1968	PARSONS Cemetery			SALISBURY, W.I. MD.					
24. FUNERAL DIRECTOR	ADDRESS			25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE					
Hill Funeral Home	SALISBURY, MD.			ARR 3-1968	Charles Judge					

